TLC Allergy & Asthma Associates, Inc.
OTTO LIAO, MD
American Board of Allergy and Immunology

Practice Limited to Allergy
www.TLCAllergy.com
Tel: 714-838-2617
Fax: 714-838-2640

Patient Full Name: _____ DOB: _____

Previous/Other Name: _____
(If different than patient listed above)

This will authorize:	**To Release to:**
_____	TLC Allergy & Asthma Associates, Inc.
_____	1076 E. 1st Street, Suite B
_____	Tustin, CA 92780

GENERAL INFORMATION REQUESTED

Medical Information Requested:

- ☐ Complete records
- ☐ X-Ray/CT reports
- ☐ Immunization records
- ☐ Other:
- ☐ Labs
- ☐ Skin testing results
- ☐ Immunotherapy serum formula

_____

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW

I specifically authorize the release of data and information relating to (Note, you must mark yes or no):

Yes	**No**	
☐	☐	Substance Abuse (alcohol/drug abuse)
☐	☐	Mental Health/Depression (includes psychological testing)
☐	☐	HIV-Related Information (AIDS related testing)

This consent may be revoked at any time by notifying the above named provider of information. Any release of information made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality. Disclosed information may be reviewed by contacting the provider of information.

***RESTRICTIONS**:*
The authorization is being given with the understanding that the receiver may not further use or disclose the medical information unless another authorization is obtained from me or unless such use of disclosure is specifically required or permitted by law.

Signature of Patient or Responsible Party: _____**Date**_____